



The Ohio Geriatrics Society
A State Affiliate of the American Geriatrics Society
2012 Membership Application

New Member

Renewing Member

Applicant Name & Contact Information				AGS Member?
				<input type="checkbox"/> Yes
				<input type="checkbox"/> No
First Name	Middle Initial	Last Name	Degree (MD, DO, etc)	
Street and Number			Phone Number	
City	State	Zip	<input type="checkbox"/> Home	Fax Number
Organization	Title		<input type="checkbox"/> Work	Email Address
If a current member recruited you, please print his/her Name			Recruiting Member's Email Address (if known)	

Membership Dues Category			
1 Year Membership (<i>OGS runs on an anniversary year and membership will be valid for one year from join/renew date.</i>)			
<input type="checkbox"/> Practicing Physician	\$50	<input type="checkbox"/> Retired	\$10
<input type="checkbox"/> Other Health Professional	\$35	<input type="checkbox"/> Resident*	\$10
<input type="checkbox"/> Fellow-In-Training		<input type="checkbox"/> Physician's Assistant	
<input type="checkbox"/> Nurse		<input type="checkbox"/> Social Worker	<input type="checkbox"/> Student*
<input type="checkbox"/> Pharmacist		<input type="checkbox"/> Other	\$10

** Trainee Memberships require appropriate verification data completed on page 2 of the application. Proof of eligibility on signed department letterhead may also be requested by the AGS Membership Office*

<input type="checkbox"/> Enclosed is my check payable to: The American Geriatrics Society
<input type="checkbox"/> Please charge to: ___Visa ___MasterCard ___American Express ___Discover
Credit Card Number: _____ Exp. Date: _____
Signature: _____ Date: _____ (required in order to process the credit card transaction)

Please complete and return with payment to:

The American Geriatrics Society
40 Fulton Street, 18th Floor
New York, NY 10038
Fax: (212) 832-8646

Questions/Queries:

Please call (212) 308-1414 or (800) 247-4779
and ask for the Membership Department

To Renew online, log in to MyAGS:

www.americangeriatrics.org/myags

(My Transactions - click Renew; credit card required)



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Membership Application

Applicant Name

Discipline

Nurse/Nurse Practitioner
 Pharmacist
 Social Worker
 Physical or Occupational Therapist
 Physician Assistant
 Scientist (non-PhD)
 Scientist (PhD)
 Other Professional

Certification Information

Primary Specialty

Emergency Medicine
 Family Medicine
 Geriatric Medicine
 Internal Medicine
 Miscellaneous/Other, please specify _____

<i>Certifying Agency</i>	<i>Specialty</i>	<i>Year Certified</i>	<i>Recertified</i>	<i>Year Recertified</i>
			<i>Y / N</i>	

***Verification Information for Trainee Members**

Residency/Student Type: Medical Graduate Nursing Undergrad Nursing Pharmacy Other

Program/School _____

Start/Matriculation Date _____ End/Graduation Date _____

Advisor/Faculty Name _____ Email _____